27. PSRO. Professional Services Review Organization. (11-10-81)

28. QMHP. Qualified Mental Health Professional. (7-1-94)

29. QMRP. Qualified Mental Retardation Professional. (4-30-92)

30. REOMB. Recipient's Explanation of Medicaid Benefits. (11-10-81)

31. R.N. Registered Nurse. (4-30-92)

32. RSDI. Retirement, Survivors, and Disability Insurance. (11-10-81)

33. SMA. State Maximum Allowance. (11-10-81)

34. SSA. Social Security Administration. (11-10-81)

35. SSI. Supplemental Security Income. (11-10-81)

36. S/UR. Surveillance and Utilization Review. (11-10-81)

37. TPL. Third Party Liability. (11-10-81)

38. UC. Utilization Control (7-1-94)

39. UCT. Utilization Control Team. (7-1-94)

40. UR. Utilization Review. (11-10-81)

005. SINGLE STATE AGENCY AND STATEWIDE OPERATION. The Idaho Department of Health and Welfare has the authority to administer the Title XIX Medical Assistance Program on a statewide basis in accordance with standards mandatory throughout the State and set forth herein. (11-10-81)

006. -- 009. (RESERVED).

010. PUBLIC ACCESS TO PROGRAM INFORMATION (7-1-93)

01. Location of Rules Governing Medical Assistance. A current copy of the rules governing medical assistance, as well as other MA program information affecting the public, is to be maintained by the Department in the Central Office and in each field office. (11-10-81)

02. Availability of Materials. Copies of the rules governing medical assistance or other MA program information affecting the public will be furnished to any individual or organization who, in accordance with Idaho Department of Health and Welfare Rules and Regulations, Title 5, Chapter 1, "Rules Governing the Protection and Disclosure of Department Records (Confidentiality)": (11-10-81)

a. Formally requests specific information; or (11-10-81)

b. Formally requests to be placed on a mailing list to receive amendments to MA program policy from the Department's Administrative Procedure Section. (11-10-81)

03. Cost of Materials. A fee, to cover actual reproduction costs, will be assessed for all requests for copies of information. (11-10-81)

011. -- 013. (RESERVED).

014. COORDINATED CARE. (6-1-94)

01. Establishment. The Department may, in its discretion, and in consultation with local communities, organize and develop area specific plans as part of a coordinated care program. (6-1-94)

a. Flexibility. Since community needs and resources differ from area to area, the Department will maintain the flexibility to design plans which are consistent with local needs and resources. (6-1-94)

b. Waiver Programs. Plans may be either voluntary, or mandatory pursuant to waiver(s) granted by the Health Care Financing Administration. Some plans may start as voluntary and subsequently become mandatory. (6-1-94)

c. Models. It is anticipated that coordinated care will be accomplished principally through primary care case management. However, capitated plans may also be utilized. (6-1-94)

d. Purpose. The purposes of coordinated care are to: (6-1-94)

i. Ensure needed access to health care; (6-1-94)

ii. Provide health education; (6-1-94)

iii. Promote continuity of care; (6-1-94)

iv. Strengthen the patient/physician relationship; and, (6-1-94)

v. Achieve cost efficiencies. (6-1-94)

02. Definitions. For purposes of this section, unless the context clearly requires otherwise, the following words and terms shall have the following meanings: (6-1-94)

a. "Clinic" means two or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs) and Certified Rural Health Clinics. (6-1-94)

b. "Coordinated care" is the provision of health care services through a single point of entry for the purposes of managing patient care with an emphasis on preventative and primary care and reducing inappropriate utilization of services and resulting costs. This is sometimes referred to as "managed care." (6-1-94)

c. "Covered services" means those medical services and supplies for which reimbursement is available under the state plan. (6-1-94)

d. "Emergency care" means the immediate services required for the treatment of a condition for which a delay in treatment could result in death or permanent impairment of health. (6-1-94)

e. "Grievance" means the formal process by which problems and complaints related to coordinated care are addressed and resolved. Grievance decisions may be appealed as provided herein. (6-1-94)

f. "Non-exempt services" means those covered services which require a referral from the primary care provider. It includes all services except those that are specifically exempted. (6-1-94)

g. "Outside services" means non-exempt covered services provided by other than the primary care provider. (6-1-94)

h. "Patient/recipient" means any patient who is eligible for medical assistance and for which a provider seeks reimbursement from the Department. (6-1-94)

i. "Plan" means the area specific provisions, requirements and procedures related to the coordinated care program. (6-1-94)

j. "Primary care case management" means the process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient. (6-1-94)

k. "Qualified medical professional" means a duly licensed physician in the following specialties: Pediatrics, Internal Medicine, Family Practice, General Practice, General Surgery, Obstetrics/Gynecology, or a physician in any other specialty who chooses to assume the function of primary care case management. It also includes nurse practitioners, and physician assistants. Licenses must be held in the state(s) where services are being rendered. (6-1-94)

l. "Referral" means the process by which patient/recipients gain access to non-exempt covered services not provided by the primary care provider. It is the authorization for non-exempt outside services. (6-1-94)

m. "Waiver" means the authorization obtained from the Health Care Financing Administration to impose various mandatory requirements related to coordinated care as provided in sections 1915(b) and 1115 of the Social Security Act. (6-1-94)

03. Primary Care Case Management. Under this model of coordinated care, each patient/recipient obtains medical services through a single primary care provider. This provider either provides the needed service, or arranges for non-exempt services by referral. This management function neither reduces nor expands the scope of covered services. (6-1-94)

a. Referrals. The primary care provider is responsible for making all reasonable efforts to monitor and manage the patient/recipient's care, providing primary care services, and making referrals for outside services when medically necessary. All outside services not specifically exempted require a referral. Outside services provided without a referral will not be paid. All referrals shall be documented in recipient's patient record. (6-1-94)

b. Exempted Services. All services are subject to primary care case management unless specifically exempted. The following services are exempt: family planning services, emergency care, dental care, Podiatry, Audiology, Optical/Ophthalmology/Optometrist services, chiropractic, pharmacy, nursing home, ICF/MR services, and immunizations. (6-1-94)

04. Participation. (6-1-94)

a. Provider Participation. (6-1-94)

i. Qualifications. Primary care case management services may be provided by qualified medical professionals, licensed to practice in the state where services are being rendered. (6-1-94)

ii. Conditions and Restrictions. (6-1-94)

(1) Quality of Services. Provider shall maintain and provide services in accordance with community standards of care. Provider shall exercise his/her best efforts to effectively control utilization of services. Providers must provide 24 hour coverage by telephone to assure patient/recipient access to services. (6-1-94)

(2) Provider Agreements. Providers participating in primary care case management must sign an agreement. Clinics may sign an agreement on behalf of their qualified medical professionals. (6-1-94)

(3) Patient Limits. Providers may limit the number of patient/recipients they wish to manage. Subject to this limit, the provider must accept all patient/recipients who either elect or are assigned to provider, unless disenrolled in accordance with the next paragraph. Providers may change their limit effective the first day of any month by written request thirty (30) days prior to the effective date of change. (6-1-94)

(4) Disenrollment. Instances may arise where the provider/patient relationship breaks down due to failure of the patient to follow the plan of care or for other reasons. Accordingly, a provider may choose to withdraw as patient/recipient's primary care provider effective the first day of any month by written notice to the patient/recipient and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. (6-1-94)

(5) Record Retention. Providers must retain patient and financial records and provide the Department or its agent access to those records for a minimum of five (5) years from the date of service. Upon the reassignment of a patient/recipient to another provider, the provider must transfer (if a request is made) a copy of the patient's medical record to the new provider. Provider must also disclose information required by section 040.01 of this chapter, when applicable. (6-1-94)

(6) Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in section 040.03 of this chapter. An agreement may be amended for the same reasons. (6-1-94)

iii. Payment. Providers will be paid a case management fee for primary care case management services in an amount determined by the Department. The fee will be based on the number of patient/recipients enrolled under the provider on the first day of each month. For providers reimbursed based on costs, such as Federally Qualified Health Centers and Rural Health Clinics, the case management fee is considered one hundred percent (100%) of the reasonable costs of an ambulatory service. (6-1-94)

b. Recipient Participation. (6-1-94)

i. Enrollment. (6-1-94)

(1) Voluntary Programs. In voluntary plans, the patient/recipient will be given an opportunity to choose a primary care provider. If the patient/recipient is unable to choose a provider but wishes to participate in the plan, a provider will be assigned by the Department. If a voluntary plan subsequently becomes mandatory, provider selection/assignment will remain unchanged where possible. (6-1-94)

(2) Mandatory Programs. In mandatory plans, a provider will be assigned if the patient/recipient fails to choose a participating provider after given the opportunity to do so. Members of the same family do not have to choose the same provider. All patient/recipients in the plan area are required to participate in the plan unless individually granted an exception. Exceptions from participation in mandatory plans are available for patient/recipients who: (6-1-94)

(A) Have to travel more than thirty (30) miles, or thirty (30) minutes to obtain primary care services; (6-1-94)

(B) Have an eligibility period that is less than 3 months; (6-1-94)

(C) Live in an area excluded from the waiver; (6-1-94)

(D) Have an eligibility period that is only retroactive; or (6-1-94)

(E) Are eligible only as medically needy. (6-1-94)

ii. Changing Providers. If a patient/recipient is dissatisfied with his/her provider, he/she may change providers effective the first day of any month by requesting to do so in writing no later than fifteen (15) days in advance. This advance notice requirement may be waived by the Department. (6-1-94)

iii. Changing Service Areas. Patient/recipients enrolled in a plan cannot obtain non-exempt services without a referral from their primary care provider. Patient/recipients who move from the area where they are enrolled must disenroll in the same manner as provided in the preceding paragraph for changing providers, and may obtain a referral from their primary care provider pending the transfer. Such referrals are valid not to exceed thirty (30) days. (6-1-94)

05. Problem Resolution. (6-1-94)

a. Intent. To help assure the success of coordinated care, the Department intends to provide a mechanism for timely and personal attention to problems and complaints related to the program. (6-1-94)

b. Local Program Representative. To facilitate problem resolution, each area will have a designated representative at the local or regional level who will receive and attempt to resolve all complaints and problems related to the plan and function as a liaison between patient/recipients and providers. It is anticipated that most problems and complaints will be resolved informally at this level. (6-1-94)

c. Registering a Complaint. Both patient/recipients and providers may register a complaint or notify the Department of a problem related to the coordinated care plan either by writing or telephoning the local program representative. All problems and complaints received will be logged. The health representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. (6-1-94)

d. Grievance. If a patient/recipient or provider is not satisfied with the resolution of a problem or complaint addressed by the program representative, he/she/ may file a formal grievance in writing to the representative. The representative may, where appropriate, refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity. However, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt. (6-1-94)

e. Appeal. Decisions in response to grievances may be appealed. Appeals by patient/recipients are considered as fair hearings and appeals by providers as contested cases under the Rules Governing Contested Case Proceedings and Declaratory Rulings, 16 IDAPA, Title 05, Chapter 03, and must be filed in accordance with the provisions of that chapter. (6-1-94)

015. CHOICE OF PROVIDERS. (7-1-93)

01. Service Selection. Each recipient may obtain any services available from any participating institution, agency, pharmacy, or practitioner of his choice, unless enrolled in a coordinated care plan. This, however, does not prohibit the Department from establishing the fees which will be paid to providers for furnishing medical and remedial care available under the MA Program, or from setting standards relating to the qualifications of providers of such care. (6-1-94)

02. Lock-In Option. (7-1-93)

a. The Department may implement a total or partial lock-in program for any recipient found to be misusing the MA Program according to provisions in Subsection 190.05.; but (12-31-91)

b. In situations where the recipient has been restricted to a recipient lock-in program, that recipient may choose the physician and pharmacy of his choice. The providers chosen by the lock-in recipient will be identified on the recipient's identification card each month. (11-10-81)

03. Out-of-State Care Provided Outside The State of Idaho. All out-of-state medical care requires preauthorization by the Department or the Department's designated Peer Review Organization (PRO), with the exception of bordering counties and emergency or urgent medical care. (2-15-93)

a. MA recipients may receive medical care and services from providers located in counties bordering Idaho without preauthorization by the Department. However PRO review may be required pursuant to Subsections 070.04. and 080.02. Approval by the Bureau of Medicaid Policy and Reimbursement, or its successor, is required for all long-term care outside the state of Idaho pursuant to Subsection 015.03.e. (2-15-93)

b. Emergency/urgent out-of-state care. (2-15-93)

i. Emergency/urgent inpatient hospital care must be reviewed using the same procedures and guidelines as in-state emergency hospital admissions by the PRO. Transfers from an Idaho Hospital to an out-of-state nonadjacent county hospital must be reviewed using the same procedures and guidelines as in-state transfers by the PRO. (2-15-93)

ii. Emergency/urgent out-of-state outpatient hospital, clinic and/or physician services do not require review by the Department or the Department's approved PRO. The provider must supply sufficient information to support a finding that the care provided was for an emergency/urgent situation. (2-15-93)

c. The Regional Medicaid Unit (RMU) will preauthorize all nonemergency care provided out-of-state for outpatient hospital services, rural health clinics, federally qualified health centers, physician services and physician extender services, dental services, podiatrists services, optometric services, chiropractor services, home health services, physical therapy services, occupational therapy services, speech and audiology services, private duty nursing, clinic services, rehabilitative services, services, and personal care services. (2-15-93)

i. A request for out-of-state preauthorization may be initiated by the recipient, the recipient's physician(s), and/or the treating facility. The preauthorization must be obtained prior to the scheduled date of the nonemergency service. Failure to request a timely authorization will result in denial of Medicaid payment for the out-of-state care and any associated transportation costs. (2-15-93)

ii. There will be no Medicaid payment if the service is determined to be available closer to the recipients residence or if no preauthorization was obtained prior to the date of the service as required. (2-15-93)

iii. The only exceptions to the preauthorization requirement are: (2-15-93)

(a) When eligibility for Medicaid is determined after the service was provided. The service still must be determined to be not available closer to the recipient's residence. (2-15-93)

(b) Out-of-state nonadjacent county lab and x-ray services when the recipient does not have to travel outside the state for the services to be provided. (2-15-93)

(c) Mail order pharmacies will not require preauthorization when the recipient is not required to travel outside the state to receive the service. (2-15-93)

(d) Services for which Medicare is the primary payer of service. (2-15-93)

i. A request for out-of-state preauthorization may be initiated by the recipient, the recipient's physician(s), and/or the treating facility. The preauthorization must be obtained prior to the scheduled date of the nonemergency service. Failure to request a timely authorization will result in denial of Medicaid payment for the out-of-state care and any associated transportation costs. (2-15-93)

ii. There will be no Medicaid payment if the service is determined to be available closer to the recipients residence or if no preauthorization was obtained prior to the date of the service as required. (2-15-93)

iii. The treating physician and the admitting facility is responsible for assuring that the Department's designated PRO has preauthorized the out-of-state nonemergency service for inpatient care. (2-15-93)

iv. No payment for services not preauthorized by the Department's designated PRO may be obtained from the recipient, absent the Medicaid recipient's informed decision to incur the cost of services. (2-15-93)

v. The only exceptions to the preauthorization requirement are: (2-15-93)

(a) When eligibility for Medicaid is determined after the service was provided. The service still must be determined not to be available closer to the recipient's residence. (2-15-93)

(b) Services for which Medicare is the primary payer of service. (2-15-93)

vi. The PRO review will be governed by provisions of the PRO provider manual as amended. (2-15-93)

e. Long-term care outside the State may be approved by the Department on an individual basis in temporary or emergency situations. Nursing home care will be limited to the period of time required to safely transport the recipient to an Idaho facility. Out-of-state care will not be approved on a permanent basis. (11-10-81)

016. -- 019. (RESERVED).

020. PROVIDER APPLICATION PROCESS. (7-1-93)

01. In-state Provider Application. In-state providers may apply for provider numbers with the Bureau. Those in-state providers who have previously been assigned a Medicare number may retain that same number. The Bureau will confirm the status for all applicants with the appropriate licensing board and assign a Medicaid provider number (s). (3-22-93)

02. Out-of-State Provider Application. Out-of-state providers who wish to participate in the Medical Assistance Program must complete a provider application and be assigned a provider number by the Bureau. The Bureau will contact a representative of Medicaid or a licensing agency in the state in which the provider practices to confirm the provider applicant's professional status and license number. (11-10-81)

03. Denial of Provider Application. The Bureau must not accept the application of a provider who is suspended from Medicare or Medicaid in another state. (11-10-81)

021. PATIENT "ADVANCED DIRECTIVES". (4-30-92)

01. Provider Participation. Hospitals, nursing facilities, providers of home health care services (home health agencies, federally qualified health clinics, rural health clinics), hospice providers, and personal care R.N. supervisors must: (4-30-92)

a. Provide all adults receiving medical care written and oral information (the information provided must contain all material found in the Department's approved advanced directive form "Your Rights As A Patient To Make Medical Treatment Decisions") which defines their rights under state law to make decisions concerning their medical care. (4-30-92)

i. The provider must explain that the recipient has the right to make decisions regarding their medical care which includes the right to accept or refuse treatment. If the recipient has any questions regarding treatment, the facility or agency will notify the physician of those concerns. Their physician can answer any questions they may have about the treatment. (4-30-92)

ii. The provider will inform the recipient of their rights to formulate advance directives, such as "Living Will" and/or "Durable Power of Attorney For Health Care." (4-30-92)

iii. The provider must comply with Subsection 021.02. (4-30-92)

b. Provide all adults receiving medical care written information on the providers' policies concerning the implementation of the recipient's rights regarding "Durable Power of Attorney for Health Care," "Living Will," and the recipient's right to accept or refuse medical and surgical treatment. (4-30-92)

c. Document in the recipient's medical record whether the recipient has executed an advance directive ("Living Will" and/or "Durable Power of Attorney for Health Care") or, have a copy of the Department's approved advance directive form ("Your Rights as a Patient to Make Medical Treatment Decisions") attached to the patient's medical record which has been completed acknowledging whether the patient/resident has executed an advance directive ("Living Will" and/or "Durable Power of Attorney for Health Care"). (4-30-92)

d. The provider cannot condition the provision of care or otherwise discriminate against an individual based on whether that recipient has executed an "Advance Directive." (4-30-92)

e. If the provider cannot comply with the patient's "Living Will" and/or "Durable Power of Attorney for Health Care" as a matter of conscience, the provider will assist the recipient in transferring to a facility/provider that can comply. (4-30-92)

f. Provide education to their staff and the community on issues concerning advanced directives. (4-30-92)

02. When "Advanced Directives" Must Be Given. Hospitals, nursing facilities, providers of home health care (home health agencies, federally qualified health centers, rural health clinics), hospice agencies, and personal care R.N. supervisors, must give information concerning "Advanced Directives" to adult recipients in the following situations: (4-30-92)

a. Hospitals must give the information at the time of the recipient's admission as an inpatient unless Subsection 021.03. applies. (4-30-92)

b. Nursing facilities must give the information at the time of the recipient's admission as a resident. (4-30-92)

c. Home health providers must give the information to the recipient in advance of the recipient coming under the care of the provider. (4-30-92)

d. The personal care R.N. supervisors will inform the recipient when the R.N. completes the R.N. Assessment and Care Plan. The R.N. supervisor will inform the QMRP and the personal care attendant of the recipients decision regarding "Advanced Directives". (4-30-92)

e. A hospice provider must give information at the time of initial receipt of hospice care by the recipient. (4-30-92)

03. Information Concerning "Advanced Directives" at the Time an Incapacitated Individual is Admitted. An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether he has executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient in accordance with state law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once he is no longer incapacitated. (4-30-92)

04. Provider Agreement. The provider will sign a "Memorandum of Understanding Regarding Advance Directives" with the Department until the "Patient's Notification of Advanced Directives" is incorporated within the Provider Agreement. By signing the Memorandum of Understanding or the Medicaid Provider Agreement, the provider is not excused from its obligation regarding advanced directives to the general public per Section 1902(a) of the Social Security Act, as amended by Section 4751 of OBRA 1990. (4-30-92)

022. -- 024. (RESERVED).

025. LIENS. No lien or encumbrance of any kind is to be required from, or imposed against, the property of any person prior to his death because of MA paid or to be paid on his behalf, or at any time if he was under sixty-five (65) years of age when he received such MA benefits except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual. (11-10-81)

026. CONDITIONS FOR PAYMENT. (7-1-93)

01. Recipient Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the MA recipient in the month of payment, provided that each of the following conditions are met: (11-10-81)

a. The recipient was found eligible for MA for the month, day, and year during which the medical care and services were rendered; and (11-10-81)

b. The recipient received such medical care and services no earlier than the third month before the month in which application was made on such recipient's behalf; and (11-10-81)

c. Not more than twelve (12) months have elapsed since the month of the latest recipient services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (11-10-81)

02. Time Limits. The time limit set forth in Subsection 026.01.c. shall not apply with respect to retroactive adjustment payments. (12-31-91)

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid recipients. Providers also agree to provide all materials and services without unlawfully discriminating

on the grounds of race, age, sex, creed, color, national origin, or physical or mental handicap. (3-22-93)

027. -- 029. (RESERVED).

030. THIRD PARTY LIABILITY. (7-1-93)

01. Determining Liability of Third Parties. The Department will take reasonable measures to determine any legal liability of third parties for the medical care and services included under the MA Program, the need for which arises out of injury, disease, or disability of an MA recipient. (11-10-81)

02. Third Party Liability as a Current Resource. In determining whether MA is payable, the Department is to treat any third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. (11-10-81)

03. Withholding Payment. The Department must not withhold payment on behalf of an eligible MA recipient because of the liability of a third party when such liability, or the amount thereof, cannot be currently established or is not currently available to pay the recipient's medical expense. (11-10-81)

04. Seeking Third Party Reimbursement. The Department will seek reimbursement from a third party for MA when the party's liability is established after MA is granted, and in any other case in which the liability of a third party existed, but was not treated as a current resource, with the exceptions of absent parent without a second valid resource, prenatal, EPSDT, and EPSDT related services. (2-4-91)

a. The Department will seek reimbursement for MA from a recipient when a recipient's liability is established after MA has been granted; and (11-10-81)

b. In any other situation in which the recipient has received direct payment from any third party resource and has not returned the money to the Department for MA service received. (11-10-81)

05. Billing Third Parties First. Medicaid providers must bill all other sources of direct third party payment, with the exception of absent parent (court ordered) without secondary resources, prenatal, EPSDT and EPSDT related services before submitting the claim to the Department. If the resource is an absent parent (court ordered) and there are no other viable resources available or if the claims are for prenatal, EPSDT, or EPSDT related services, the claims will be paid and the resources billed by the Department. (2-4-91)

06. Accident Determination. When the patient's Medicaid card indicates private insurance and/or when the diagnosis indicates an accident for which private insurance is often carried, the claim will be suspended or denied until it can be determined that there is no other source of payment. (11-10-81)

07. Third Party Payments in Excess of Medicaid Limits. The Department will not reimburse providers for services provided when the amount received by the provider from the third party payor is equal to or exceeds the level of reimbursement allowed by MA for the services. (11-10-81)

08. Subrogation of Third Party Liability. In all cases where the Department will be required to pay medical expenses for a recipient and that recipient is entitled to recover any or all such medical expenses from any third party, the Department will be subrogated to the rights of the recipient to the extent of the amount of medical assistance benefits paid by the Department as the result of the occurrence giving rise to the claim against the third party. (11-10-81)